Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRECKENRIDGE SURGERY CENTER
3201 EAST GEORGE BUSH SUITE 100
RICHARDSON TX 75082

Respondent Name

ARCH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2372-01

MFDR Date Received

MARCH 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Medicare ASC facility reimbursement for procedure 26952 is $660.35, in Collin County. The allowable per the Texas Workers' Comp fee schedule is $660.35 (Medicare allowable) X 235% = $1551.82. Please issue additional payment of $274.05."

Amount in Dispute: $463.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 22, 2012: "We have escalated the MDR for an additional review by the bill auditing company. That review is currently in process. We will supplement a response once that review has been completed."

Respondent's Supplemental Position Summary dated July 12, 2012: "The bill has been confirmed as processed correct and the denial of CPT 11012 is appropriate."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2011	ASC Services for CPT Code 26952-SG	$274.05	$274.02

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - 18-Duplicate claim/service.

Issues

1. Is the requestor entitled to additional reimbursement for CPT code 26952-SG?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 26952 is defined as "Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   According to Addendum AA, CPT code 26952 is a non-device intensive procedure.

   The City Wage Index for Richardson, Texas is 0.9860.

   The Medicare fully implemented ASC reimbursement for code 11012 CY 2011 is $665.00

   To determine the geographically adjusted Medicare ASC reimbursement for code 11012:

   The Medicare fully implemented ASC reimbursement rate of $665.00 is divided by 2 = $332.50

   This number multiplied by the City Wage Index is $332.50 X 0.9860 = $327.84.

   Add these two together $332.50 + $327.84 = $660.34.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $660.34 X 235% = $1,551.79. The respondent paid $1,277.77. The difference between the MAR and amount paid is $274.02. As a result, this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $274.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $274.02 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		06/05/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.